Phillip G. Davis, M.D.
7560 Winkler Rd
Fort Myers, FL 33908
Ph: (239) 454-6868 / Fax: (239) 466-5254

Authorization to Use or Disclose Health Information

Patient Name: _____

Social Security Number: _____ **DOB:** _____

Email(Please Print Clearly): _____

- I authorize the use of disclosure of the above named individual's health information as described below.
- The following individual(s) or organization(s) are authorized to make the disclosure:
  Name: _____ Phone: _____ Fax: _____
  Address: _____
- The type of information to be used or disclosed is as follows: COMPLETE MEDICAL RECORDS, INCLUDING OFFICE NOTES, X-RAYS, EKGS, DIAGNOSTICS TESTS, ETC... SPECIAL ATTENTION TO: _____
- The information identified above may be used by or disclosed to the following individual(s) or organization(s): Phillip G Davis, M.D.
- This information for which I am authorizing disclosure will be used for the following purpose:
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest claim under my policy.
- Unless I specify differently, this authorization will expire _____ (insert date or event). If I fail to specify an expiration date or even, this authorization will expire six months from the date on which it was signed.
- I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
- I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____
Signature of patient or legal representative Date

If signed by legal representative, relationship to patient: _____

_____ _____
Signature of witness Date

- I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that I must specifically authorize such disclosure.

_____ _____
Signature of patient or legal representative Date

If signed by legal representative, relationship to patient _____

_____ _____
Signature of witness Date